

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2020
NAME OF PROVIDER OR SUPPLIER TREVECCA CENTER FOR REHABILITATION AND HEALING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 329 MURFREESBORO RD NASHVILLE, TN 37210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page 4 items in Resident #1's medical file. Further interview with the Administrator on his expectations on the process of inventory and retrieval of residents' belongings confirmed that staff should make a list of items on an inventory sheet on admission, any valuables would be locked up and any items picked up would be signed for by the person picking up said items.	F 602			